ficial and easily felt, and is well above the origin of the deep femoral. The femoral pulse being felt, he made a stab-puncture in the skin, one about an inch outside the pulse, and the other about two inches to its inner side—*i. e.*, immediately below the pubic spine. An aneurism needle was pushed from one stab-puncture well behind the artery and vein to the other stab-puncture, and two long, thick, silk ligatures were carried back when it was withdrawn. A roll of compressible material was placed over the artery and the two ligatures tied separately over it, after the limb had been elevated for a sufficient length of time to empty it of blood. The knots are not firmly fastened at first, a surgeon's knot is used, held by hæmostats, so that they can be readily made tighter if it is found necessary.

The same result can be attained by making one puncture and pushing one blade of a Doyen's broad ligament forceps beneath the vessels, and then clamping them, but this requires an extra instrument and is not available in an emergency.

The Abdominal Incision Through the Sheath of the Rectus Muscle, with the Displacement of its Lateral or Median Margin.—LENNANDER (*Centralblatt für Chirurgie*, 1898, No. 4) has used this incision in many cases of appendicitis, and believes it is preferable except where firm adhesions hold the appendix in the lumbar region or in the lateral portion of the iliac fossa and where drainage is necessary. It is especially useful in operations during the interval, where the exact position of the appendix can usually be determined beforehand. In all cases where the cæcum and appendix are freely movable this incision gives better results and allows in women the thorough exploration of the adnexa, which are also frequently involved.

The direct incision through the rectus muscle has the disadvantages of cutting the vasa epigastrica inferiora, of generally cutting the muscular branches of the nerves and producing atrophy, and in addition the scars of the incision directly through the different layers of the abdomen are in close relation to each other.

The method the author advocates is through the skin, then through the anterior fibres of the sheath of the rectus one-half to three-quarters of an inch from the external margin of the muscle and toward the median line.

On the right side, if for appendicitis. The wound is thoroughly dried, the border of the rectus carefully freed and gently displaced inward. One or two nerves accompanied by vessels are seen now crossing the field diagonally to the muscle. The vessels are tied and cut. In almost all operations the nerves can be displaced to the upper or lower angle of the wound and remain unharmed throughout the operation. The posterior layer of the rectus sheath is now incised, and with it the peritoneum opposite the skin incision.

The wound is afterward closed by layers of sutures separate from the peritoneum and posterior layer of the sheath; the muscle is then replaced, its margin attached by sutures, the anterior layer of the sheath sutured separately. The skin is closed with deep and superficial sutures of silkworm-gut, the deep sutures including the sheath of the rectus. Drainage or even packing may be employed in the area anterior to the rectus sheath, if deemed necessary.

The advantages of this method are the great extent of the scar or wound surface, the possibility in simple operations of avoiding the nerves, presence between the two incisions in the rectus sheath of a living muscle that is entirely intact, and that the incision is made through an area well supplied by bloodvessels, which is not the case in incisions in the linea alba or semilunaris.

The same method may be applied to all abdominal incisions in the median line by making the incision through the sheath just outside the median border of the rectus muscle.

After a large number of operations by this method, the author is perfectly satisfied with his results, and has seen no tendency to hernia.

The Anatomy and Treatment of Flat-foot.—Long, narrow feet are, according to CLARKE (*Lancet,* April 23, 1898), the most likely to become flattened from pressure on the highest part of the arches, so that in extreme cases the whole of the inner border of the foot rests upon the ground.

The treatment adopted by the author consists in wearing boots properly shaped—*i. e.,* having soles that are sufficiently wide anteriorly for the toes. They are furnished with pads of vulcanized rubber, so formed that the highest part falls in front of the transverse tarsal joints. In addition, an outside leg-iron, jointed at the ankle and supported by an inside T-strap, is applied in some cases. Manual wrenchings and douchings are also helpful, and as soon as sufficient improvement has been obtained suitable exercises may be begun. These exercises are useful, and in suitable cases may alone suffice. (1) Rising on tip-toe a definite number of times, the toes being inclined inward. (2) Adduction of the foot, repeated several times. (3) Walking for a short time daily on the outer border of the foot.

Another form of flat-foot that often demands complete rest for a time is that observed in active rickets. Every case requires its own management of complications, of which hallux valgus and hammer-toe are the commonest. To correct these deformities the author employs a metal sole of proper shape, with a toe-post to hold the great toe in position and slots for the insertion of a soft bandage which holds the other toes in their proper position.

Tibio-tarsal Disarticulation with a Flap Containing the Periosteum of the Calcaneum.—The results obtained from this method of amputation, which were first described by Ollier, have lately been studied by LA BOMEARDIÈRE (*Revue de Chirurgie,* September, 1897) by means of skiagraphs which show that there results a reproduction of bone from the periosteal flap of the calcaneum which varies in its opacity to the Röntgen ray in proportion to the length of time it has been formed. In all its states it, however, formed a firm support for the weight of the body, the amount of new bone depending to a great extent upon the age of the calcaneum removed. The cicatrix is entirely anterior, and is not subject to pressure.

The functional result is excellent, shortening is reduced to a minimum, walking is easy, and the deformity produced is readily hidden by an appropriate apparatus.

There are many marks of superiority over other older methods; there is less traumatism; there is absolute security from an operative stand-point